

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Queen Anne
City or town near Millington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Queen Anne
City or town near Millington
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lilly C. Anthony
4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Wm. F. Anthony
deceased 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 10 - 1867

8. AGE: Years 80 Months 2 Days 15 It less than one day _____ hrs. _____ min.

9. Birthplace Queen Anne Co. Ind.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Edward Larimore

13. Birthplace Ind.

14. Maiden name Annie Costin

15. Birthplace Ind.

16. Informant Mr. E. Larimore

Address Church Hill Ind.

17. Burial Date thereof Jan. 27 - 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Centerville

Location Centerville Ind.

18. Funeral director Edgar L. Lane

Address Church Hill Ind.

19. 1-27 48 Edgar L. Lane
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 21 - 48 at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 to Jan 27 1948

and that I last saw her alive on Jan. 24 1948

Immediate cause of death Hemiplegia

Due to Arterio-sclerosis

Due to Chronic Intestinal Myeloma

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Muriel Price M. D. or other _____

Address Millington Mo. Date signed Jan. 27/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00815

Reg. Dist. No. 202

1. PLACE OF DEATH:

County..... Queen Anne
 City or town..... Kingstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 5 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Queen Anne
 City or town..... Kingston
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Mamie Essie Atkinson

3. (b) Social Security Number

no

4. Sex..... female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... married
 6. (b) Name of husband or wife..... John M. Atkinson
 6. (c) If alive, give age..... 58 years
 7. Birth date of deceased (mo., day, yr.)..... Jan. 10, 1884
 8. AGE: Years..... 63 Months..... II Days..... 24 If less than one day..... hrs. min.

9. Birthplace..... Kent Co. Maryland
 (Town, county, and state)
 10. Usual occupation..... housewife
 11. Industry or business.....

FATHER
 12. Name..... Charles Henry Smith
 13. Birthplace..... Maryland
 MOTHER
 14. Maiden name..... Emma W. Smith
 15. Birthplace..... Maryland

16. Informant..... Mr. John M. Atkinson
 Address..... Chestertown, Md. R.F.D.
Burial
 17. (Burial, cremation, or removal. Which?)..... Date thereof..... Jan. 6, 1948
 (month) (day) (year)
 Cemetery or crematory..... Wesley Chapel Cem.
 Location..... Rock Hall, Maryland

18. Funeral director..... J. Willis Wells
 Address..... Chestertown, Md.

19. Date rec'd by registrar..... Jan. 5, 1948 Registrar..... Clara S. Barnes

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan. 4th, 1948 at..... 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Aug. 1945 to..... Jan. 2, 1948
 and that I last saw him alive on..... Jan. 2, 1948

Immediate cause of death..... Carcinoma of uterus DURATION..... 1945
 Due to.....
 Due to.....
 Other conditions..... Metastases
 (Include pregnancy within 8 months of death)

Major findings of operations..... 3 Date of op..... 1945
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Manner of injury..... Injured at work?

23. SIGNATURE..... Frank M. Smith M. D. or other.....
 Address..... Chestertown Date signed..... Jan 5/48

RECEIVED

JAN 12 1948

U. S. DEPT. OF JUSTICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00816

Reg. Dist. No. 253

1. PLACE OF DEATH:

County Queen Anne'sCity or town Centerville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Centerville
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Sarah Maria Bland

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) May 6 - 1870

8. AGE:

Years

Months

Days

If less than one day

7782

hrs.

min.

9. Birthplace

Christ Hill 24 Co. Md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER
MOTHER

12. Name

William Cole

13. Birthplace

Pennsylvania

14. Maiden name

Sarah Bland

15. Birthplace

Pennsylvania

16. Informant

Mrs. Lurline M. Cole

Address

Centerville Md

17.

Burial
(Burial, cremation, or removal, which?)

Date thereof

Jan 11 - 48
(month) (day) (year)

Cemetery or crematorium

Chestnut Hill

Location

Centerville Maryland

18. Funeral director

Barton Bros

Address

Centerville Maryland

19.

Jan 10 - 48
(Date rec'd by registrar)Elie Armstrong
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 7 - 1948 at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 7 to Jan 8 19 48
and that I last saw him alive on Jan 7 19 48

Immediate cause of death

Procha Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

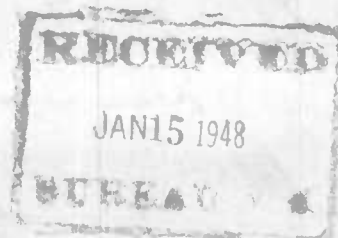
Injured at work?

23. SIGNATURE

H. M. Thomas

M. D. or other

Address Centerville Md Date signed 1/10/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00817

Reg. Dist. No. 253

1. PLACE OF DEATH:

County Queen Anne's

City or town Chester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Queen Anne's

City or town Chester
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Alvin D. Brown

3. (b) Social Security Number

4. Sex male 5. Color or race col. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bertie F. Brown

7. Birth date of deceased (mo., day, yr.) Jan 20 - 1898 6. (c) If alive, give age 43 years

8. AGE: Years 50 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace MD
(Town, county, and state)

10. Usual occupation Operator

11. Industry or business _____

12. Name Frank Brown

13. Birthplace MD

14. Maiden name Marie Pruchaska

15. Birthplace MD

16. Informant Bertie Brown

Address Chester

17. Burial Date thereof 1-26-48
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Chester (col.)

Location Chester MD

18. Funeral director Elton E. Lane

Address Church Hill MD

Jan 25 1948 Elizabeth Foster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 25 1948 at 1 a . M 30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1948 to Jan. 25 1948

and that I last saw him alive on January 23 1948

Immediate cause of death

Carcinoma of
(primary) bladder

DURATION

2

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Theodor Sattelmair, M.D.

Address Stevensville Date signed 1/27/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Chesler AnneCity or town Chester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State MD County FrederickCity or town Chester
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Roderick Blyssum Brown

3.(b) Social Security Number

4. Sex male5. Color or race col.

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Mary H. Brown

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 6 - 18798. AGE: 69 Years 0 Months 0 Days 0 Hrs. 0 Min.9. Birthplace MD
(Town, county, and state)10. Usual occupation Shucking oysters

11. Industry or business

12. Name Pecahemyer Brown13. Birthplace P. A. Co14. Maiden name Sarah J. W. Co15. Birthplace MD16. Informant Jack BrownAddress Chester, MD17. Burial Date thereof Jan 25 - 48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Chester (col)Location Chester, MD18. Funeral director Edgar L. LaneAddress Charm Hill, MD19. Jan 25 - 48 Elizabeth H. Harte
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22 1948, at 6 P. 20 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 20 1948, to Jan. 22 1948and that I last saw him alive on January 21 1948

Immediate cause of death _____ DURATION _____

Arteriosclerosis _____Due to chronic nephro-sclerosis _____Due to sclerosis coronary artery _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Theodor Sattelmair M.D.Address Stevensville _____Date signed 1/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:

County..... Queen Anne's
 City or town..... Smiltington md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 weeks
 Hospital, institution, or street address where death occurred:
Palomatory
 How long in hospital or institution?..... 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Queen Anne's
 City or town..... Smiltington md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Eva Culley

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 6. (b) Name of husband or wife..... Joseph Culley
 6. (c) If alive, give age..... 81 years
 7. Birth date of deceased (mo., day, yr.)..... Dec. 23, 1870
 8. AGE: Years..... 77 Months..... 0 Days..... 10 If less than one day..... hrs..... min.

9. Birthplace..... Kent County, Md.
 (Town, county, and state)
 10. Usual occupation..... Housewife
 11. Industry or business..... Home

12. Name..... James Newcomb
 13. Birthplace..... Kent Co. Md.
 14. Maiden name..... Emma Rhodes
 15. Birthplace..... Kent Co., Md.
 16. Informant..... Joseph Culley
 Address..... Lynch, Md.
 17. Burial..... Date thereof..... Jan 6 1948
 (Burial, cremation, or removal, Which?)..... (month) (day) (year)
 Cemetery or crematory..... Still Pond
 Location..... Still Pond, Md.
 18. Funeral director..... B. F. Fellows
 Address..... Still Pond, Md.
 19. 1-6..... 48..... J. M. Black
 (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 3..... 1948 at..... 12:30 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... Dec. 20..... 1947 to..... Jan 3..... 1948
 and that I last saw him..... alive on..... Jan 3..... 1948

Immediate cause of death..... Wernia
 DURATION..... 6 days

Due to..... Ch. Myocarditis + Nephritis
 Duration..... Several years

Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)
 Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other
 Address..... Wilmington, Md. Date signed..... Jan 5/48

CERTIFICATE OF DEATH

RECEIVED
FEB 4 1948
STREET V M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, and be correct as to sex, age, date of death, and cause of death. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County... Queen Anne
 City or town... Suddersville Md., Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... MD. County... Queen Anne
 City or town... Suddersville Md. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

William Eugene Daniels

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

Dec 2, 1947

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

014

hrs.

min.

9. Birthplace

Chestertown, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

William Junior Daniels

13. Birthplace

Suddersville Md.

MOTHER

14. Maiden name

Nettie Lavinia Thomas

15. Birthplace

Suddersville Md.

16. Informant

Nettie Lavinia Thomas

Address

Suddersville Md.

17.

(Burial, cremation, or removal, which)

Date thereof

(month) (day) (year)

Cemetery or crematory

Bethel Cemetery

Location

Pondtown, Md.

18. Funeral director

Edward E. Hower

Address

Millington Md.

19.

(Date rec'd by registrar)

19

1-6-48 Edgar L. Kane
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 6 19 48 at 4:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-2 19 47 to 1-6 19 48and that I last saw him alive on 1-6-48 19 48Immediate cause of death probable congestive heart diseaseas he had been apparently well for 2weeks ago, began eating poorly. Thiscontinued up to date of death, though entirelyDue to normal physical examination.

Other conditions _____

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert W. Kane M.D.

M. D. or other _____

Address Chestertown, Md. Date signed 1-6-48

RECEIVED

JAN 12 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00821 254

1. PLACE OF DEATH:

County Luzerne
 City or town Queensbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? all his life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Massachusetts County Luzerne
 City or town Queensbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

John Griffin Embert

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

B. (b) Name of husband or wife Mammina Gould Embert7. Birth date of deceased (mo., day, yr.) October 5-1874 8. (c) If alive, give age 68 years8. AGE: Years 73 Months 3 Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Rural Queensbury Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name John R. H. Embert
13. Birthplace Maryland14. Maiden name Cecilia Griffin
15. Birthplace Maryland16. Informant Mrs. Mammina R. EmbertAddress Queensbury Maryland17. Burial Date thereof Jan 9-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter'sLocation Queensbury Maryland18. Funeral director Barton BrosAddress Centerville Maryland19. Jan. 8 19 48 Helen M. Aldridge
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 6th 1948 at 7 35 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29 1947 to January 6 1948 and that I last saw him alive on January 6 1948Immediate cause of death Carcinoma of prostate glandDue to pneumoniaDue to chronic bronchiectasisOther conditions myocardial degeneration
(Include pregnancy within 3 months of death)DURATION
several
yearsDec 30, 19471 years2

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

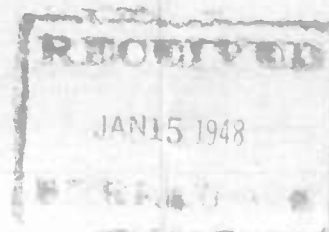
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodor Sattelmair M.D.Address Stevensville M. D. or otherDate signed Jan 7, 1948



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 251

1. PLACE OF DEATH

County Queen Anne'sCity or town Rural Millington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County KentCity or town Rural Millington
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

unknown

8. AGE:

Years

Months

Days

If less than one day

unknown

_____ hrs. _____ min.

9. Birthplace _____

(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business _____

FATHER

12. Name

Joseph Martin

13. Birthplace

MOTHER

14. Maiden name

Jane Moore

15. Birthplace

16. Informant

Mrs. Bill Ingrall

Address

Clayton Del.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan 23, 1948

(month) (day) (year)

Cemetary or crematory

Hall's

Location

near Millington Md

18. Funeral director

Edward J. Taylor

Address

Millington Md19. 1-21-48

(Date rec'd by registrar)

Edgar L. Lane

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19 1948 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2 1947 to Jan 19 1948and that I last saw him alive on Jan 18 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Cerebral Arteriosclerosis

Due to

Chronic Hypertension

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

C. N. Wiltcalfe

M. D. or other

Address

Ind. Ave. N.E., Wash.Date signed 1/22/48

RECEIVED
JAN 26 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County Superior
 City or town Radcliff
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? None
 Hospital, institution, or street address where death occurred: None

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Virginia County Superior
 City or town Radcliff
 (If outside city or town limits, write RURAL and give nearest town)

Street No. None
 (If rural, give LOCATION)

2.(a) If veteran, name was

3. (a) FULL NAME

Kilda Roberts

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) March 24 - 1984 6. (c) If alive, give age 19 years

8. AGE: 63 Years 9 Months 19 Days If less than one day hrs. min.

9. Birthplace Superior, Va.
 (Town, county, and state)

10. Usual occupation Nurse11. Industry or business Nurses12. Name Superior Co. Radcliff13. Birthplace Superior, Va.14. Maiden name Edgar15. Birthplace Superior, Va.16. Informant Edgar L. LaneAddress Radcliff Rd17. Burial Date thereof Jan 6 - 48

(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Superior, Va.Location Superior, Va.18. Funeral director Edgar L. LaneAddress Church Hill Rd19. 1-3 19 48 Edgar L. Lane

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 19 48 at 2 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 48 to Jan 8 19 48and that I last saw him alive on Jan 8 19 48Immediate cause of death Heart failure DURATIONHigh blood pressureDue to Heart failureDue to Heart failureOther conditions Heart failure

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE Edgar L. Lane M.D. or otherAddress Church Hill Rd Date signed Jan 8 19 48

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UNITED STATES DEPARTMENT OF THE ARMY
HEADQUARTERS, ARMY
WASHINGTON, D. C.

RECEIVED
JAN 26 1948
OFFICE

21-1-48
Enclosed
for the
Director
of the
Army
Medical
Department
100-100000-100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:

County 99 BaltimoreCity or town Sudlersville Ind
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Queen Anne'sCity or town Sudlersville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harv Scott Stanley

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M6. (b) Name of husband or wife Doris Stanley6. (c) If alive, give age 75 years7. Birth date of deceased (mo., day, yr.) Jan 24, 18928. AGE: Years 75 Months 11 Days 30 If less than one day _____ hrs. _____ min.9. Birthplace 99 CO
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Charles W Stanley

13. Birthplace

14. Maiden name Edna W Stanley

15. Birthplace

16. Informant Harv Scott StanleyAddress Buwal17. Date there 1-26-48
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Sudlersville IndLocation Edgar B. Lane18. Funeral director Church Hill Ind.

Address

19. 1-26-48
(Date rec'd by registrar)Edgar B. Lane
Registrar

MEDICAL CERTIFICATION 1948

20. DATE OF DEATH Jan 23 19 48 at 6:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 16 19 48 to Jan 23 19 48and that I last saw him alive on Jan 17-2 19 48

Immediate cause of death

DURATION

Due to Chronic myocardial

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Stanley

M. D. or other

Address Sudlersville Ind Date signed 1/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH: Green Anne
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME Mary E. Walbert

3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife R. J. Walbert
 6.(c) If alive, give age 73 years
 7. Birth date of deceased (mo., day, yr.) April 22-1881

8. AGE: Years 66 Months 9 Days 4 If less than one day
hrs.min.

9. Birthplace Ingleide Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Geo. Morris

13. Birthplace Selkirk

14. Maiden name Ellen Lynch

15. Birthplace 2nd Co. Md

16. Informant R. J. Walbert Husband

Address Perice Md

17. Burial Date thereof 1-28-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Centerville

Location Centerville Ind

18. Funeral director Edgar R. Lane

Address Church Hill Ind.

19. 1-28 19 48 Edgar R. Lane
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 19 48 at 8:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1- 19 48 to Jan 26 19 48
 and that I last saw her alive on Jan 25 19 48

Immediate cause of death Robert Pneumonia DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

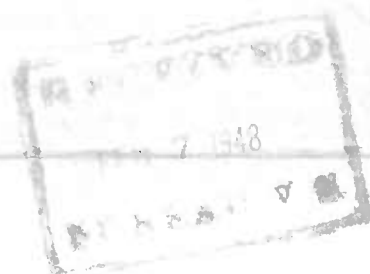
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Harvey Fisher M. D. or other

Address Centerville Ind Date signed 1/28/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Queen Anne's
City or town Chester
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Queen Anne's
City or town Chester
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, same war

3.(a) FULL NAME

Geo. W. York Sr

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Mary Albert York
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 4 - 1876 (1876)

8. AGE: Years 71 Months 6 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Reisterstown Md
(Town, county, and state)

10. Usual occupation Weaver in mill

11. Industry or business

12. Name Don't Know

13. Birthplace "

14. Maiden name Don't Know

15. Birthplace Don't Know

16. Informant Mrs. Anna York

Address Chester Md

17. Burial Date thereof Jan. 48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Holy Family

Location Bethesda Co.

18. Funeral director J.F. Elmer Sons

Address Reisterstown Md.

19. Jan 15 48 Elizabeth Koster
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 19 48 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____ and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death He was found dead in the yard & he had Red Very high blood.
Due to Washed - from jacket
obtained from
Due to excessive cerebral hemorrhage

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE W. J. Fisher

Address 117-48 Date signed 1/17-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 20 1948
BUREAU